Special Article

Medi-Cal Hospital Contracting—Did It Achieve Its Legislative Objectives?

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The 1982 Medi-Cal reforms and reductions established selective contracting with hospitals for inpatient care of Medi-Cal beneficiaries. The legislation established a special negotiator and criteria to be used in selecting contract hospitals. We report the findings of a study that analyzed the characteristics of contract and noncontract hospitals in Los Angeles County to assess how well these criteria were reflected in the outcome of the contracting process. We examine issues of beneficiary access to general inpatient care and to specialized services, the efficiency of contract hospitals compared with noncontract ones and quality-related issues.

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In 1982, Medi-Cal (California's medicaid program) was an obvious target for state legislators who were looking for ways to reduce the state's expected $2 billion deficit. In fiscal year 1981-1982, Medi-Cal expenditures amounted to $4.8 billion, about $1 in every $8 of state expenditures, of which 57% came from state sources and 43% represented the federal contribution. Furthermore, costs were rising rapidly. Between fiscal years 1975-1976 and 1981-1982, Medi-Cal expenditures increased nearly $2 billion, with cost per service contributing 58% of the increase and number of eligible persons adding 11% to the expenditure increase.[1] Faced with these problems, leaders in the legislature—with strong support from the governor and business, labor and insurance industry groups—enacted a series of bills despite objections from the hospital industry and the medical profession.[2]

Among the far-reaching cutbacks and reforms included in Assembly Bill 799, Assembly Bill 3480, and Senate Bill 2012, probably the most significant reform was the decision to selectively contract with hospitals for inpatient care provided to Medi-Cal recipients. The objective of selective contracting was to encourage hospitals to engage in price competition for a share of the Medi-Cal business. A special negotiator was to be appointed, with unusual authority to set negotiating procedures and to conclude contracts with hospitals that would reimburse them on any basis except the old cost-based, fee-for-service system. Once this process was concluded, inpatient care to Medi-Cal recipients would be restricted to those hospitals that had signed contracts. Exceptions would be made for emergency care, care in children's and other specialized hospitals, "crossover" patients (those with Medicare and Medi-Cal) and members of prepaid health plans.

In this article we examine the results of the Medi-Cal selective contracting process with hospitals in Los Angeles County. Variables or characteristics that distinguish contract from noncontract hospitals are analyzed to assess the extent to which criteria established by the legislature were achieved in the outcome of the contracting.

Medi-Cal Hospital Contracting

The special negotiator was fully responsible for negotiating the rates, terms and conditions of the contracts. The legislation exempted the contracts from review and approval by state oversight agencies normally required for contracting services. However, the legislature mandated nine factors, in addition to price, to be considered in negotiating contracts: (1) beneficiary access; (2) utilization controls; (3) ability to render quality services efficiently and economically; (4) demonstrated ability to provide or arrange needed special services; (5) protection against fraud and abuse; (6) any other factor that would reduce costs, promote access or enhance the quality of care; (7) the capacity to provide a given tertiary service, such as specialized children's services, on a regional basis; (8) recognition of the variations in severity of illness and complexity of care, and (9) existing labor-management collective-bargaining agreements.

William Guy, former president of Blue Cross Association of Southern California, was named special negotiator and was

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ABBREVIATIONS USED IN TEXT

ADC = average daily census of patients
AFDC = Aid to Families With Dependent Children
CHFC = California Health Facilities Commission
FTE = full-time equivalent employees
HFPA = Health Facilities Planning Area
NICU = neonatal intensive care unit
PSRO = Professional Standard Review Organization

soon dubbed the "Czar" because of his broad powers. In order to implement the process quickly, Guy chose to reimburse hospitals with a flat per diem rate. He also initially insisted that the contract terms remain secret as provided by the legislation. The secrecy provision, however, prevents the public from knowing even retrospectively a hospital's bid price, the final contract price or the provisions of the contract. Secrecy also makes it difficult for the public or researchers to assess how effectively the Czar fulfilled the legislated criteria to be used in hospital contracting.

Despite the secrecy surrounding the bid prices and the negotiated per diem rates, it is widely known, and was acknowledged in an interview with Guy on March 23, 1983, that acceptable bids were targeted to average about 10% below a hospital's previous average costs reimbursed by the Medi-Cal program. Thus, hospitals were expected to offer per diem rates based on their historical costs, rather than competing against other hospitals' prices. Nevertheless, there is no evidence that hospitals were told, or that they figured out, that a particular historically based price was expected of them. Because not all hospitals' bids were being accepted and because at least some hospitals that badly wanted contracts were turned down, there is every reason to believe that hospitals perceived themselves to be competing with each other—both in bid price and in services and terms offered. Hospitals throughout the state took this competition seriously after three hospitals in San Francisco that had provided inpatient care to 40% of that city's Medi-Cal recipients did not receive contracts. After filing legal challenges to their exclusion, these hospitals later were given contracts, but the effect of this early rejection had a significant impact on other hospitals in California.[3]

Negotiations were conducted individually with all hospitals in one or a few clustered Health Facilities Planning Areas (HFPAs), health planning units previously designated by the state and used by the Czar as the basic geographic contracting unit. Negotiations continued until the Czar achieved at least the targeted contracted bed capacity and negotiations were completed with all facilities especially sought by the Czar. The area was then "closed."

Negotiations began in Los Angeles County in November 1982 and lasted for seven months. Virtually all of the acute care general hospitals in Los Angeles County applied for contracts. By May 1983, contracting in 17 of the county's 19 HFPAs had been completed. Of the 136 hospitals in these closed areas, contracts were awarded to all 6 county hospitals (100%) and 78 private hospitals, the latter making up 60% of the 130 not-for-profit and investor-owned acute care general hospitals in the area.

Because the details of the contracts and of the decision-making process are still secret, the purpose of this article will be to deduce from the only information available to the public—that is, the names of hospitals with contracts and available data and characteristics of the hospitals themselves—how well the legislated criteria were implemented in awarding contracts. Because the criteria included issues of access and quality-related characteristics, this analysis will permit some assessment of the hospital services available to Medi-Cal recipients as a result of the contracts.

Methodology

Contracting and noncontracting hospitals were compared on the basis of qualitative and quantitative data that would provide a profile of a hospital's characteristics that reflect the legislative criteria and be readily available. For several legislative objectives—protection against fraud and abuse (criterion 5), presence of labor management collective bargaining contracts (9) and, of course, price—information was not available for analysis.

Data for all 136 short-term acute-care general hospitals in Los Angeles County that were eligible for contracting were obtained from the California Health Facilities Commission,[4] American Hospital Association,[5] Hospital Council of Southern California,[6] California Department of Health Services,[7] Office of the Special Negotiator,[8] the Health and Hospital Marketing Databank[9] and local Professional Standards Review Organization (PSRO) offices.* Other information pertaining to the negotiating process was obtained from interviews with current and former officials of the California Department of Health Services, the Office of the Special Negotiator and hospital administrators. Hospitals in the two HFPAs in Los Angeles County that had not yet been closed at the time of this study have been excluded from the analysis. Also excluded from the analysis were Children's Hospital of Los Angeles, psychiatric and drug rehabilitation hospitals and other specialty facilities that had been exempted from the contracting process.

Beneficiary Access

Two of the legislative criteria (1 and 6) specifically direct the Czar to consider access in negotiating contracts. In this analysis, three dimensions of access were considered: disruption of sources of inpatient care that some Medi-Cal recipients will experience because their usual hospitals did not receive contracts, a phenomenon generally termed "redirection"; availability of entry points into the inpatient system through hospital outpatient services, and availability of specialty inpatient services.

Redirection

Disruption of Medi-Cal recipients' patterns of care was measured by comparing the percentage of Medi-Cal patient-days in contract and noncontract hospitals before the contract system. It is widely assumed that preventing Medi-Cal recipients from using certain hospitals would, in itself, disrupt their patterns of care and constitute some temporary reduction in access. We examined the percentage of Medi-Cal patient-days in contract and noncontract hospitals reported to the California Health Facilities Commission (CHFC) during fiscal year 1980-1981. Of the more than one million Medi-Cal patient-days, 83.8% were provided in hospitals that subsequently received Medi-Cal contracts (Table 1).

*Dr Daniel Wilner of the Health and Hospital Marketing Databank assisted us.

Thus, some 16.2% of Medi-Cal patients in Los Angeles County had to change from their previous source of inpatient care to another hospital. The percentage of redirected patient-days in Los Angeles County is comparable with that of the state as a whole. Statewide, in areas closed by August 1983, 14% of Medi-Cal patient-days would be redirected. Although admissions or discharges would be a better measure of redirection, the CHFC reports only patient-days by a patient's source of payment. Because the data are used comparatively, patient-day provides a satisfactory, relative measure of redirection. (Statewide, 15% of discharges would be redirected, compared with 14% of patient-days.[10])

The percent of redirection varies considerably among HFPAs. The HFPAs range from no redirection in four HFPAs to 100% redirection in HFPA 937, which had a tiny Medi-Cal inpatient volume. In HFPAs with more than 10% redirection, one or two noncontract hospitals that previously had substantial Medi-Cal loads account for most of the redirection. For example, in HFPA 909, one noncontract hospital accounts for 93.3% of redirected patient-days; in HFPA 917, one hospital accounts for 84.2%, and in HFPA 927, one hospital accounts for 72.9%. In HFPA 915, three hospitals account for 83.1% of redirection. In several HFPAs, redirection is spread over several hospitals, most of which had very small shares of the Medi-Cal service volume in the HFPA.

TABLE 1.—*Proportion of Medi-Cal Patient-Days Redirected From Noncontract Hospitals**

Area	Total Medi-Cal Patient-Days in Acute Care Hospitals, FY 1980-1981	Percent of Medi-Cal Patient-Days in Noncontract Hospitals, FY 1983-1984
Los Angeles County	1,003,425	16.2
HFPA 901	32,114	4.2
HFPA 903	22,299	2.2
HFPA 905	49,019	24.2
HFPA 907	21,841	0.0
HFPA 909	21,258	12.1
HFPA 911	21,116	9.8
HFPA 913	53,860	17.0
HFPA 915	31,257	80.6
HFPA 917	18,706	32.9
HFPA 919	20,083	0.0
HFPA 921	122,447	6.2
HFPA 923	35,757	0.0
HFPA 925	305,687	15.9
HFPA 927	62,946	42.1
HFPA 933	126,353	16.2
HFPA 935	57,782	0.0
HFPA 937	900	100.0

FY=fiscal year, HFPA=Health Facilities Planning Area

*From the Report to the Legislature on the Operations of the Office of Special Health Care Negotiations, Appendix K[8] and Individual Hospital Data for California, 1980-1981.[4]

Clearly, not granting contracts to hospitals with large shares of their HFPA's Medi-Cal volume constitutes a change in the source of inpatient care for a substantial number of persons. Although any disruption of patterns of care-seeking may be undesirable, redirecting inpatient care alone is probably the least disruptive because, compared with ambulatory care, it is infrequently used by most beneficiaries and because doctors, not patients, usually determine the hospital to which a patient is admitted. Hospital contracting applied to inpatient care only, not emergency room or outpatient department use—although a few hospitals, like Cedars-Sinai in Los Angeles, tried to redirect their Medi-Cal outpatients to contract hospitals when they did not get a contract. Except for cases such as Cedars-Sinai, the disruption is undoubtedly more problematic for admitting physicians than for their patients unless the contract hospitals are a considerable distance from a patient's home.

As is obvious from the percent of redirection resulting from the contracting outcomes, the contracting process favored hospitals that had provided greater shares of Medi-Cal inpatient days in their HFPA. County hospitals, of course, were the largest Medi-Cal providers in their areas, accounting for an average of 55.3% of the Medi-Cal inpatient days for their HFPAs. Among private hospitals, those that received contracts provided an average of 13.2% of their HFPA inpatient days compared with 7.9% for noncontract hospitals (data not shown in table form).

Entry to Inpatient Care

For many Medi-Cal patients, emergency rooms are an entry point to hospital inpatient care as well as an important source of ambulatory care. Although finding emergency room physicians willing to admit and care for Medi-Cal patients has been a continuing problem in the Medi-Cal program, it is assumed that such patients have a better chance of being admitted when necessary if a hospital has at least a basic emergency room with a physician on duty than if it has only standby or first-aid referral services or no emergency license at all.

Of the hospitals that received contracts, 59.5% have at least basic emergency rooms (Table 2). All but two HFPAs include one or more contract hospitals with at least basic emergency services. Because Medi-Cal recipients may receive emergency inpatient and outpatient care from any licensed hospital, even in those HFPAs without basic emergency services under contract, Medi-Cal patients have

TABLE 2.—*Contract and Noncontract Hospitals by Particular Services Available**

Service	Contract Hospitals: County	Contract Hospitals: Private	Contract Hospitals: Total (%)	Noncontract Hospitals (%)	All Hospitals
At least basic emergency room	4/6†	46/78‡	50/84 (59.5)	33/51 (64.7)§	135
Obstetrical services	3/6†	47/78‡	50/84 (59.5)	22/52 (42.3)§	136
Neonatal intensive care unit	3/6†	13/78‡	16/78 (19.0)	3/52 (5.8)§	136

*From Annual Roster and Press Manual,[6] Health Facilities Directory,[7] Report to the Legislature on the Operations of the Office of the Special Health Care Negotiations, Appendix K[8] and 1984 Hospital Marketing Directory: Hospitals in Southern California.[9]

†County hospitals with service versus total county hospitals.

‡Private contract hospitals with service versus total private contract hospitals.

§Private noncontract hospitals with service versus total private noncontract hospitals.

TABLE 3.—*Contract and Noncontract Hospitals by Peer Group**

Type of Hospital	Contract Hospitals			Noncontract Hospitals (%)	All Hospitals (%)
	County (%)	Private (%)	Total (%)		
Teaching or large complex	3 (9.1)	20 (60.6)	23 (69.7)	10 (30.3)	33 (100.0)
Moderately complex	†	22 (56.4)	22 (56.4)	17 (43.6)	39 (100.0)
Smaller urban and rural	†	29 (61.7)	29 (61.7)	18 (38.3)	47 (100.0)
Other	3 (17.6)	7 (41.2)	10 (58.8)	7 (41.2)	17 (100.0)

*From Individual Hospital Data for California, 1980-1981[4] and Report to the Legislature on the Operations of the Office of Special Health Care Negotiations, Appendix K.[8]

†No Los Angeles County Department of Health Services hospital of this type.

the same access to emergency services as other insured population groups. But in one HFPA with more than 31,000 general acute care inpatient days reported in 1980-1981, Medi-Cal recipients may experience less access to inpatient care under the contract arrangements because none of the contract hospitals has a basic emergency room. Despite the generally adequate distribution of contract hospitals with emergency rooms, hospitals without even basic emergency rooms were slightly more likely to receive contracts than hospitals with them.

Specialty Inpatient Services

In addition to the criteria that specifically mentioned access, the legislature also mandated the Czar to consider a hospital's "ability to provide or arrange needed specialized services" (criterion 4), an access-related concern. Once appointed, the Czar indicated that certain services of special importance to Medi-Cal patients would be considered in the contracting process. Obstetrical care is important to the Medi-Cal population because, with the elimination of medically indigent adults from Medi-Cal and the continued ability of elderly Medi-Cal patients with Medicare to obtain inpatient care from any licensed hospital, a large proportion of Medi-Cal beneficiaries affected by selective contracting are recipients of Aid to Families With Dependent Children (AFDC) and AFDC-related medically needy persons.

Of all contract hospitals, 59.5% have obstetrical units (Table 2). Only one small HFPA is without obstetrical services in contract hospitals. The Czar estimates that the availability of such services is adequate for the Medi-Cal population's needs, but it is difficult to determine from the data whether or not they are sufficiently accessible. With these services and with emergency care, travel times to such hospitals must be taken into account as well as availability of obstetricians who accept Medi-Cal (an issue beyond the control of the Czar) to adequately evaluate access.

Of the 72 hospitals in Los Angeles County with obstetrical services, 69.4% received contracts. Thus, it appears that the contracting favored hospitals with obstetrical services and that the accessibility of these services to Medi-Cal beneficiaries is at least minimally protected.

Similarly, access to neonatal intensive care is important to Medi-Cal recipients, a disproportionately high percentage of whom are likely to have high-risk pregnancies and low-birthweight or distressed infants. Of all contract hospitals, 19.0% have a neonatal intensive care unit (NICU), compared with only 5.8% of noncontract hospitals (Table 2). Because relatively few hospitals have an NICU, there are five HFPAs without any contract or noncontract hospital that provides neonatal intensive care services. One additional HFPA includes a noncontract private hospital that provides an NICU. This pattern indicates that the Czar generally contracted with at least one hospital with an NICU in each HFPA when such hospitals were available.

Technical Complexity

The reform legislation instructed the Czar to consider a hospital's ability to provide tertiary care needed on a regional basis (criterion 7) and, in effect, include within a given area adequate provisions for more severe or complex medical problems (criterion 8). A hospital's ability to provide a complex level of care could be measured by the range or quantity of services it provides. An alternative method available in California is simply to compare hospitals on the basis of their classification by the CHFC into peer groups based on size, scope of service, service volumes and other factors.

Of the four peer group combinations considered in this study, teaching and large complex hospitals were more likely to receive contracts than the other three types (Table 3). Seven of every ten such tertiary care hospitals received contracts compared with about six of every ten among all technically less complex facilities. These more complex hospitals tended to be high-volume Medi-Cal providers so there was a strong incentive for the Czar to include them within the Medi-Cal contract system.

Four HFPAs are without any teaching or large complex hospital, either contract or noncontract. Three of these HFPAs are fairly rural areas with relatively low population density. One, however, is an urban area with a large low-income population. Though there was no tertiary care hospital in the HFPA with which the Czar could have contracted, it is a fairly narrow HFPA and Medi-Cal recipients may have adequate access to tertiary care hospitals in neighboring HFPAs. In addition to these four HFPAs that have no large technically sophisticated hospitals, another HFPA has a teaching or large complex hospital not under contract; this is a surburban area with several low-income communities, apparently none of which is near a tertiary care hospital under contract to the Medi-Cal program.

Quality of Care and Utilization Controls

The legislature directed the Czar to consider a hospital's "ability to render quality services" (criterion 3) and also specifically mentioned quality in criterion 6. In addition, Guy expressed a desire to include as many "name" hospitals as possible; these are generally large, prestigious hospitals with a broad scope of services and widely recognized as providing good quality medical care. They are also likely to have teaching programs. Quality of care is difficult to measure. It

would also have been difficult to develop a list of "name" hospitals because a survey of physicians or patients in the county was not feasible for this study.

We used two measures that are quality-*related*—delegated PSRO status and teaching status. A hospital with a utilization review mechanism approved by the Professional Standards Review Organization may be considered both as a recognized method of controlling utilization (criterion 2) and as a measure of quality, assuming the utilization review identifies and corrects grossly inappropriate medical practices. Hospitals that do not have approved internal review procedures and committees must submit to external review by the area PSRO. The value of PSRO delegation as a measure of quality is limited in part by variations in the ease with which different regional PSROs delegate responsibility to hospitals.

Utilization review has been developed mainly to control excessive utilization. This was a problem for third-party payers because fee-for-service and cost-based reimbursement systems create incentives for physicians and hospitals to do more procedures and services than may actually be needed. The new Medi-Cal per diem method of reimbursing hospitals reverses that incentive for hospitals (though not for physicians), providing incentives to do less for patients because hospitals receive the same daily rate regardless of how many services are used. Utilization review committees may concern themselves with such issues, although existing computerized monitoring systems in the Medi-Cal program cannot identify patterns of "underutilization" because they were designed for "overutilization." In any case, PSRO delegation remains a useful, albeit imperfect, measure for judging quality assurance.

Delegated PSRO status is closely associated with teaching status, which is taken as an additional quality-related factor. (Teaching status and PSRO delegation are not completely independent variables. Among the 127 hospitals for which information about both variables was available, 90.9% of the teaching hospitals have PSRO delegation compared with 56.2% of the nonteaching hospitals.) Hospitals with even modest teaching programs are more likely to attract physicians with a higher degree of technical proficiency than hospitals with no teaching component. Of course, the technical influence of teaching programs may be limited to the services included in the program, but in any given area we assumed that having a teaching program would give the hospital a favorable reputation within the medical community.

Hospitals with PSRO delegation were only slightly more likely to receive contracts than those without it. Of the 79 hospitals in Los Angeles County with delegation, 64.6% received contracts, compared with 60.4% of the 53 hospitals without delegation (Table 4). The contracting process thus resulted in a slightly higher percentage of contract hospitals having PSRO delegation (61.4%) than noncontract hospitals (57.1%).

Contract hospitals are far more likely than noncontract hospitals to have teaching programs. Of the 22 hospitals in the county with American Medical Association-approved residency programs, 20 (90.9%) received Medi-Cal contracts (Table 5). Because of the small number of teaching hospitals, they still constitute only 24.4% of all contract hospitals.

Operating Efficiency

The legislature directed the Czar to consider a hospital's ability to provide services "efficiently and economically" (criterion 3). For this study, contract and noncontract hospitals were compared on the basis of two measures of efficiency: occupancy rates, because it was assumed that hospitals with fewer empty beds would be able to spread all their fixed costs and some of their variable costs across more revenue-producing patients, and the ratio of full-time equivalent (FTE) employees to average daily census (ADC) of patients, because hospitals with lower FTE/ADC ratios use less staff per patient. To adjust for the occupancy and staffing differences related to hospital size and complexity of care, contract and noncontract hospitals were analyzed within peer groups. FTE/ADC ratios were available for only 107 of the hospitals in this study. Smaller urban and rural hospitals and "other hospitals" are especially plagued by lack of information on this variable, introducing potentially substantial errors in the findings for these peer groups and possibly the "all hospitals" figures. The more complex hospital peer groups should not be much affected.

The mean occupancy rate for contract hospitals was 55.6% compared with 49.5% for noncontract hospitals

TABLE 4.—*Contract and Noncontract Hospitals by PSRO Delegation**

PSRO Delegation	Contract Hospitals			Noncontract Hospitals (%)	All Hospitals (%)
	County	Private	Total (%)		
Delegated	6	45	51 (64.6)	28 (35.4)	79 (100.0)
Nondelegated	0	32	32 (60.4)	21 (39.6)	53 (100.0)

PSRO=Professional Standards Review Organization

*From Report to the Legislature on the Operations of the Office of Special Health Care Negotiations, Appendix K.[8] PSRO delegated-status information was obtained by personal communication from each regional PSRO office.

TABLE 5.—*Contract and Noncontract Hospitals by Teaching Programs**

Teaching Programs	Contract Hospitals			Noncontract Hospitals (%)	All Hospitals (%)
	County	Private	Total (%)		
Has program	5	15	20 (90.9)	2 (9.1)	22 (100.0)
No program	1	61	62 (57.4)	46 (42.6)	108 (100.0)

*From Guide to the Health Care Field[5] and Report to the Legislature on the Operations of the Office of Special Health Care Negotiations, Appendix K.[8]

(Table 6). Both contract and noncontract hospitals that were more complex tended to have higher occupancy rates than less complex facilities. Only among the most complex peer group did noncontract hospitals have higher occupancy on the average than contract hospitals.

Contract hospitals tend to have larger ratios of FTE employees to average daily census (Table 7). These differences remain even within three of the four peer group categories, with hospitals offering more complex care having higher FTE/ADC ratios as expected. Interestingly, moderately complex hospitals have higher mean FTE/ADC ratios than teaching and large complex hospitals. (When only private hospitals are compared, contract and noncontract teaching and large complex hospitals have essentially the same ratios, 4.9 and 4.8, respectively, suggesting that often the sicker and more difficult-to-manage cases in the county hospitals require more staffing.)

Although contract hospitals have slightly higher occupancy rates, they also may have higher FTE/ADC ratios. The occupancy rates are probably not sufficiently higher among the contract hospitals to affect their average costs per patient-day, but their FTE/ADC ratios do suggest greater expense per patient-day for this variable cost factor. Without access to the bid or final contract prices, it is impossible to know whether these differences were reflected in higher per diem bids. However, these data do suggest that if efficiency was taken into account by the Czar, other factors weighed more heavily in the award of contracts.

Commitment to the Poor

In addition to examining the Czar's fulfillment of legislated criteria, other issues aroused concern among many observers. One concern, expressed by us and other analysts, was the prospect that hospitals with a demonstrated commitment to serving the poor might not receive contracts whereas hospitals that had no such commitments might underbid to keep their options open in a time of uncertainty. The argument in support of this hypothesis was that hospitals that were heavily dependent on Medi-Cal revenues would have to bid their average costs because Medi-Cal patients made up such a large share of their total patient-days, and that hospitals with a low volume of Medi-Cal service could bid their marginal costs (which would be lower than average costs) because Medi-Cal charges were a relatively insignificant part of their revenue. The fear was that hospitals that had shown a commitment to serving the poor but that did not receive contracts might become so financially distressed that they would be forced to close, depriving the poor and the community of socially useful institutions. Guy did not alleviate this concern when he announced early in the negotiating process that he would treat every hospital as a competitor in an economic market and not as a social institution that must be preserved.

TABLE 6.—*Occupancy Rate of Contract and Noncontract Hospitals by Peer Group**

Peer Group	Contract Hospitals (%)	Noncontract Hospitals (%)
All hospitals	84 (55.6)	52 (49.5)
Teaching and large complex hospitals	23 (64.9)	10 (68.7)
Moderately complex hospitals	22 (55.4)	17 (53.4)
Smaller urban and rural hospitals	29 (50.2)	18 (43.0)
Other hospitals	10 (50.0)	7 (29.2)

*From individual Hospital Data for California, 1980-1981[4] and Report to the Legislature on the Operations of the Office of Special Health Care Negotiations, Appendix K.[8]

TABLE 7.—*FTE/ADC Ratio of Contract and Noncontract Hospitals by Peer Group**

Peer Group	Contract Hospitals (%)	Noncontract Hospitals (%)
All hospitals	70 (5.6)	37 (4.9)
Teaching and large complex hospitals	22 (5.3)	10 (4.8)
Moderately complex hospitals	20 (6.5)	16 (5.1)
Smaller urban and rural hospitals	20 (5.2)	10 (4.6)
Other hospitals	8 (5.1)	1 (7.1)

FTE/ADC=full-time equivalent [employees] to average daily census.

*From individual Hospital Data for California, 1980-1981,[4] Guide to the Health Care Field[5] and Report to the Legislature on the Operations of the Office of Special Health Care Negotiations, Appendix K.[8]

A hospital's commitment to serving the poor was measured by several factors: the percentage of its inpatient and outpatient revenues derived from serving Medi-Cal patients; the ratio of outpatient visits to inpatient days, because low-income persons are more dependent on clinics and hospitals for ambulatory care than are the more affluent and adequately insured population, and whether the hospital reported an operating deficit in fiscal year 1980-1981. Operating deficits are associated with providing uncompensated care to uninsured and poor patients and with serving a greater proportion of Medi-Cal recipients because Medi-Cal paid a lower percentage of all costs than did other third-party payers. In 1979, Blue Cross and commercial insurance companies reimbursed hospitals 12% more than their "full financial requirements" (including the actual costs of providing care plus working capital and capital replacement costs), Medicare reimbursed them 4% less than their full costs and Medi-Cal paid them 18% less than their full costs, according to a study by the CHFC.[11]

County hospitals, as expected, have the greatest commitment to serving the poor as shown by their great dependence on Medi-Cal inpatient and outpatient revenues (Table 8). Similarly, they have a high average ratio of outpatient visits to inpatient days. All six county hospitals reported an operating deficit in 1980-1981, as they do every year.

Private hospitals that received contracts were substantially more dependent on Medi-Cal for their inpatient revenues than noncontract hospitals, and they were slightly more dependent on Medi-Cal for their outpatient revenues as well, although they had slightly lower ratios of outpatient visits to inpatient days. More than a third of all private contract hospitals reported operating deficits in 1980-1981 compared with only a fourth of their noncontract counterparts.

Discussion and Conclusion

The analysis of the outcome of the hospital contracting process in Los Angeles County suggests that the criteria established by the legislature were substantially achieved. First, access by Medi-Cal beneficiaries to inpatient hospital care seems to be reasonably well protected by selective contracting. A small percentage (16.2%) of Medi-Cal patient days must be redirected from noncontract hospitals to facilities with contracts, though the percentage of redirection within HFPAs varies considerably. Access to emergency

TABLE 8.—*Commitment to Serve the Poor by Contract and Noncontract Hospitals and Ownership**

Commitment to Serve the Poor	Contract Hospitals		Noncontract Hospitals	Number
	County	Private		
Mean percent inpatient revenue from Medi-Cal (%) . . .	37.9	13.4	8.3	128
Mean percent outpatient revenue from Medi-Cal (%) . .	11.0	3.3	3.0	136
Mean ratio of outpatient visits per inpatient day (%) . .	2.0	0.9	1.3	128
Percent hospitals with operating deficit reported in 1980-1981 (%)	100.0	35.9	26.9	136

*From Individual Hospital Data for California, 1980-1981,[4] and Report to the Legislature on the Operations of the Office of Special Health Care Negotiations, Appendix K.[8]

room services through which Medi-Cal recipients might be admitted to hospital for nonemergency problems seems generally adequate, although two HFPAs are without any contract hospital that has at least a basic emergency room. Only one HFPA has no obstetric inpatient services under contract. Access to neonatal intensive care services is more restricted because relatively few hospitals have such services. Two HFPAs seem deficient in the availability of technically sophisticated inpatient care, though one of the HFPAs is a rural area that is not far from other areas with contract hospitals.

Second, technically more sophisticated hospitals, especially those with teaching programs, were more likely to receive contracts. Whether these are truly higher quality hospitals is difficult to judge although our indicators—having a teaching program and PSRO delegation to an in-hospital utilization review committee—suggest that contract hospitals are, at the very least, not inferior.

Third, contract hospitals tend to have higher occupancy rates (except among teaching and large complex hospitals), but they also have higher ratios of full-time staff to average daily census. Although the Czar may have taken these or other measures of efficiency into account, other factors obviously carried more weight in the contracting process.

Fourth, hospitals with a demonstrated commitment to serving the poor tended to be more successful in winning contracts. In addition to the county hospitals, private hospitals that were more dependent on Medi-Cal inpatient revenues were more likely to receive contracts than hospitals that derived smaller percentages of their revenue from Medi-Cal. Similarly, hospitals that had reported operating deficits in fiscal year 1980-1981 were also more likely to receive contracts.

The contracting process seems to have worked well in Los Angeles County. The legislature's criteria were substantially met, Medi-Cal beneficiaries had access to inpatient care in general and to specialized and technically complex services in facilities of at least average quality. In general, hospitals with a demonstrated commitment to serving the poor are well represented among contract hospitals. It seems clear that the Czar considered hospital characteristics in a manner consistent with the legislature's criteria.

Some caution is warranted in concluding that Medi-Cal selective contracting is an unqualified success. First, this study has some methodologic limitations. The analysis has been made without measures of performance for several legislated criteria—protection against fraud and abuse, presence of labor-management collective bargaining contracts and price—and has used very imperfect measures of another criterion—quality. In addition, the analysis is based on hospitals only in Los Angeles County; the results of the contracting process may be somewhat different in other counties.

Second, this analysis focuses only on the outcome of the negotiating process—which hospitals got contracts and which did not—and characteristics of the Medi-Cal inpatient hospital system in place at the conclusion of the contracting process. We do not yet have any evidence concerning the long-term effect of contracting on either Medi-Cal recipients or on hospitals. It may work as it has been optimistically envisioned. Medi-Cal patients may not suffer any significant loss of access. Medi-Cal hospitals may make up in increased volumes for the (on average) lower patient-day revenues they now receive from Medi-Cal and simply eliminate unnecessary services they formerly provided to patients. On the other hand, contracting may develop into the more pessimistic scenario that many have predicted. Medi-Cal recipients' actual access to health care may be restricted considerably more than this analysis suggests. Contract hospitals with a heavy Medi-Cal load may receive substantially less revenue than their costs, have greater difficulties obtaining capital and end up providing second-class care to Medi-Cal recipients or closing their doors altogether.[2,3]

Our findings support the conclusion that the special negotiator substantially implemented the criteria for Medi-Cal selective contracting with hospitals established by the legislature, as represented by the outcome of contract negotiations in Los Angeles. It is too early, however, to judge the actual immediate or long-term consequences of the program on beneficiaries or hospitals.

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